

## MEDICAL HISTORY QUESTIONNAIRE: THYROID CANCER

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Coverage Information:

Type:  Term  UL  IUL  
 WL  VUL  Survivorship

Face Amount: \_\_\_\_\_

Premium Tolerance: \_\_\_\_\_

### Proposed Insured's Existing Insurance

Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis \_\_\_\_\_

2. Does the client currently smoke cigarettes?  Yes  No

a. If no, did he/she ever smoke?  Never  Quit (date) \_\_\_\_\_

3. Does the client currently use any other tobacco products? (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum, etc.)

Yes  No

a. If yes, please provide details: \_\_\_\_\_

4. When did he/she last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type last used: \_\_\_\_\_

5. Type of thyroid cancer:  Papillary  Mixed Papillary  Follicular  
 Hurthle Cell  Primary thyroid lymphoma  Medullary  
 Anaplastic

6. Tumor confined?  Yes  No

7. Tumor size:  Less than 4 centimeters  4 centimeters or more (extracapsular extension)

8. Lymph node involvement/metastasis?  Yes  No

9. Stage of cancer: \_\_\_\_\_

10. Cancer Treatment:  Surgery  Radiation  Chemotherapy

a. Treatment Start Date: \_\_\_\_\_ Treatment End Date: \_\_\_\_\_

11. Any evidence of recurrence?  Yes  No If yes, provide date/details below: \_\_\_\_\_

12. Please list current medications

Name of Medication	Dosage	Reason

13. Are there any other health issues? (Additional Questionnaires may be required)  No  Yes

If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_